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THE STILLBIRTH AND INFANT MORTALITY FOR WOONSOCKET, R. I. IN 1936

Compared with Statistics for 1925

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In 1936 there were 826 new born babies in Woonsocket, R. I. Of this number there were forty stillbirths and fifty-six infant deaths. This gives a stillbirth rate of 4.8 per one hundred live births, an infant death rate of 67.7 per 1,000 live births, of which forty-one deaths or 73.2 percent were neonatal deaths. These rates are higher by direct comparison with the United States Registration Area and the Maternal and Child mortality of the State of Rhode Island.

The present study was made for the purpose of: 1. Obtaining information regarding fetal and maternal conditions associated with fetal mortality. 2. To ascertain if possible, the varied causes associated with infant mortality. 3. To attempt to compare statistics obtainable at the present time with those obtained in a similar survey made in Woonsocket, R. I. in 1925.

The study in 1925[1] and the present survey were made through the use of birth and death records and through home interviews of the mothers of the children. All histories were rechecked for accuracy.

As very few cases have come to autopsy the immediate cause of death as shown upon the death certificate was accepted in all cases as directly responsible for the loss of infant life.

From Table I, we may note a decrease in the number of stillbirths and an improvement in the number of cases reported as unknown. Eleven or 27.5 percent of the total cases were reported as cause unknown in 1936, compared with 19 cases or 43.2 percent reported in 1925. This is encouraging. Better prenatal care is emphasized by the lowered mortality in albuminuria of the mother, where there is a definite improvement.

Read before the staff at Woonsocket Hospital, December 13, 1937. From the Rhode Island State Department of Public Health.

TABLE I

CAUSES OF STILLBORN DEATHS IN WOONSOCKET FOR 1925 AND 1936

Cause	1925 Number	1925 Percent	1936 Number	1936 Percent
All Causes	44	100.0	40	100.0
Unknown	19	43.2	11	27.5
Asphyxia	5	13.6	10	25.0
Birth Injury	1	2.3	6	15.0
Premature	5	11.4	.....	.....
Dystocia	2	4.5	.....	.....
Albuminuria of Mother	5	11.4	2	5.0
All other causes	6	13.6	2	5.0
Congenital malformation	.....	.....	7	17.5
Infection of Mother	.....	.....	2	5.0

Birth injuries, which include dystocia, prolonged labor and pelvic abnormalities, show an increase. There is an increase in congenital malformations, including hydrocephalus, anencephlus, spina bifida and other malformations. Asphyxia, which includes separation of the placenta, abnormalities of the cord and other causes, has also increased. The two maternal infections were pneumonia and chronic tuberculosis.

TABLE II

CAUSES OF NEONATAL DEATHS IN WOONSOCKET IN 1925 AND 1936

Cause of Death	1925 Number	1925 Percent	1936 Number	1936 Percent
All Causes	55	100.0	*†40	100.0
Premature Birth (159)	21	38.2	17	42.5
Congenital Debility (158)	8	14.5	.....	.....
Birth Injuries (160)	5	9.1	10	25.0
Malformations (157)	2	3.6	7	17.5
Respiratory Diseases (107)	6	10.9	2	5.0
Gastrointestinal Diseases (119)	4	7.3	2	5.0
Infections	.....	.....	.....	.....
Other Causes (161)	9	16.4	2	5.0

*Includes 3 deaths at Woonsocket Hospital, out of city residence.

†To this total if we add 3 deaths from congenital malformations, 7 deaths from respiratory diseases, 2 deaths from gastrointestinal diseases and 2 infections in children between 1 month and 1 year, we have the total infant deaths for 1936.

Table II shows a definite decrease in the loss of life from neonatal deaths. A comparison of forty neonatal deaths in 1936 compared with fifty-five in 1925, shows that there is a marked improvement in the intervening years as a result of the work of all persons interested in infant welfare.

Premature births show a very slight increase, congenital malformations and birth injuries are also increased. They may be explained, no doubt, by a difference in opinion regarding the classification of the various records.

TABLE III

AGE AND CAUSE OF DEATH—NEONATAL DEATHS IN WOONSOCKET FOR 1925

	All Causes	Prematurity	Congenital Debility	Injuries at Birth	Malformations	Respiratory Diseases	Gastric and Intestinal Diseases	All Others
Total	55	21	8	5	2	6	4	9
Less than 15 minutes	6	2	.....	1	.....	.....	.....	3
15 min., less than 30	.....	.....	.....	.....	.....	.....	.....	.....
30 min., less than 1 hour	1	.....	.....	.....	1	.....	.....	.....
1 hour, less than 24	9	8	1	.....	.....	.....	.....	.....
1 day, less than 2	4	3	1	.....	.....	.....	.....	.....
2 days, less than 3	6	3	1	1	.....	.....	1	.....
3 days, less than 7	10	1	1	2	1	1	1	3
1 week, less than 2	7	2	.....	1	.....	2	1	1
2 weeks, less than 1 mo.	12	2	4	.....	.....	3	1	2

TABLE IV

AGE AND CAUSE OF DEATH—NEONATAL AND INFANT DEATHS IN WOONSOCKET FOR 1936

	All Causes	Prematurity	Congenital Debility	Injuries at Birth	Malformations	Respiratory Diseases	Gastric and Intestinal Diseases	All Others
Less than 15 minutes	5	2	.....	2	.....	.....	.....	1
15 min., less than 30	3	1	.....	.....	1	.....	.....	1
30 min., less than 1 hour	3	1	.....	1	1	.....	.....	.....
1 hour, less than 24	9	7	.....	1	1	.....	.....	.....
1 day, less than 2	7	3	.....	2	2	.....	.....	.....
2 days, less than 3	2	2	.....	.....	.....	.....	.....	.....
3 days, less than 7	6	1	.....	3	2	.....	.....	.....
1 week, less than 2	2	.....	.....	1	.....	1	.....	.....
2 weeks, less than 1 mo.	2	.....	.....	.....	.....	1	1	.....
1 month, less than 2	1	.....	.....	.....	.....	.....	1	.....
Neonatal Deaths	40	17	.....	10	7	2	2	2
2 months, less than 3	4	.....	.....	.....	1	2	.....	1
3 months, less than 6	7	.....	.....	.....	2	4	1	.....
6 months, less than 1 yr.	7	.....	.....	.....	.....	2	2	3
Total Infant Deaths	58	17	.....	10	10	10	5	6

Improvement in deaths from respiratory diseases and gastrointestinal diseases point definitely to improvement in feeding and in early infant care. It shows better cooperation between family, physician and nurse. It reflects the effect of early health education.

It can be properly assumed that most of the infant deaths occur during the first month of life, and that infant mortality is considered one of the most sensitive barometers by which measurements of the health of a community may be made. Anything that is done to decrease infant mortality must be done during the first month or certainly during the first year of infant life.

TABLE V

A COMPARISON OF THE INFANT MORTALITY BY CAUSE IN THE 1921 BIRTH REGISTRATION AREA OF THE UNITED STATES, 1931 TO 1935 INCLUSIVE, WITH WOONSOCKET, 1936[2].

Cause of Death	Deaths Under 1 Yr. per 1,000 Live Births					Woonsocket
	1931	1932	1933	1934	1935	1936
All Causes	60.0	55.8	54.3	55.8	51.6	70.2
Natal and Prenatal Causes [1]	32.2	31.2	31.3	31.4	29.5	44.8
Gastrointestinal Dis. [2]	6.6	5.2	5.0	5.5	4.3	6.1
Respiratory Diseases [3]	11.0	9.9	9.0	9.3	8.8	12.1
Epidemic and other communicable dis. [4]	2.7	2.7	2.3	3.0	2.4	7.2
External Causes [5]	0.7	0.9	0.9	1.0	1.0	
All other causes [6]	4.5	4.1	4.0	4.0	4.1	
Unknown or ill-defined Diseases	2.1	1.9	1.8	1.7	1.6	

1. Natal and prenatal causes include: Premature birth, congenital malformations, injury at birth, congenital debility, other diseases of early infancy, syphilis, tetanus.

2. Gastrointestinal diseases include: Diarrhea and enteritis, diseases of stomach, dysentery.

3. Respiratory diseases include: Bronchiti, bronchopneumonia, lobar and unspecified pneumonia, influenza.

4. Epidemic and other communicable diseases include: Measles, scarlet fever, whooping cough, diphtheria, erysipelas, epidemic cerebrospinal meningitis, tuberculosis of the respiratory system, tuberculosis of the meninges and the central nervous system, other forms of tuberculosis.

5. All other causes include: Convulsions, intestinal obstruction, all other causes of death.

A comparison of Table III and Table IV, shows that half of the neonatal deaths in 1936 occurred during the first 24 hours. This would account for the early premature infants and the severe birth injuries that no doubt could not survive even under the best of circumstances. The other fifty percent of neonatal deaths are graded through the various causes in about the same proportion with regard to duration of life.

Eighteen cases of infant deaths occurred between one month and one year of age, and it should be noted that in this group we find that eight infants died from respiratory diseases, three from gastrointestinal diseases and three congenital malformations.

In 1925, sixteen neonatal cases died during the first twenty-four hours and of these, ten babies died from prematurity. However, as the age increased, the number of deaths from prematurity decreased, as can be expected. Respiratory disease was the cause of death of six children, gastric and intestinal diseases caused four deaths. The effect of improved care is reflected by a review of the 1936 statistics.

Woonsocket presents an increase of 14.7 deaths or 70.2 deaths per 1,000 live births[3] compared with a five year average of 55.5 deaths per 1,000 live births for the United States Registration Area from 1931 to 1935 inclusive.

The State of Rhode Island averaged forty-six infant deaths per 1,000 live births in 1936[4].

MATERNAL DEATHS

The maternal death rate in Woonsocket, has decreased from 1930 to 1935, but in 1936, because of certain accidents at birth, there has been considerable increase. It is encouraging to note that during 1936, there were 352 births or 42.3 percent that were delivered either in Woonsocket Hospital or in a hospital in Providence, Pawtucket or Central Falls. This one fact should do much to help lower the maternal mortality and aid in helping Woonsocket mothers to realize what good obstetrical care means.

TABLE VI

MATERNAL DEATHS (3) OF WOONSOCKET FOR 1930 TO 1936 INCLUSIVE

Year	Live Births	Maternal Deaths	Death Rate
1930	931	6	6.4
1931	822	6	7.3
1932	821	6	7.3
1933	755	6	7.9
1934	777	3	3.9
1935	841	2	2.4
1936	826	7	8.5

A new addition of fifteen beds to Woonsocket Hospital as a maternity wing for those who constitute the low wage level group should also mean improvement. There were 474 births, 57.7 percent, delivered at home.

As certain causes of maternal deaths play an interesting role in the deaths of Woonsocket mothers, it is of importance to make a special study as to age of mother, cause of death and place of delivery.

TABLE VII

CAUSES OF MATERNAL DEATHS IN WOONSOCKET (3) FOR 1936, DISTRIBUTED AS TO CAUSE OF DEATH, AGE OF MOTHER, TIME AND PLACE OF DEATH

Month	Cause of Death	Age of Mother	Home or Hospital
March	Shock, following Cæsarian birth (14a)	36	Hospital
April	Puerperal sepsis (145) Phlebitis (148)	35	Hospital
June	Puerperal hemorrhage (144) Tumor, abdominalis	45	Hospital
July	Puerperal hemorrhage (144) Placenta Previa	27	Hospital
August	Ectopic pregnancy (142) Shock-hemorrhage	32	Hospital
October	Hyperthroiditis (66) 7½ months pregnant	25	Hospital
December	Puerperal sepsis (145) Placenta Previa	27	Hospital

One case of acute cardiac failure is included as a seven and a half months pregnancy following the belief that pregnancy increases the incidence of cardiac failure in such cases. Three of the deaths were from hemorrhage, following conditions that complicated delivery. There were two deaths from puerperal sepsis, both hospital cases.

These accidents again forcibly remind us of the need of Health Education in Woonsocket, and need of better instructions to Woonsocket mothers as to good obstetrics. It is impossible for the physicians to do their best work when it is a known fact that many pregnant mothers consult their physician in the eight month or more often not until labor has started. These conditions must be overcome if we are to make satisfactory headway.

In the Study of 1925, it was noted "Two mothers of babies included in this study died at childbirth. One mother had convulsions and kidney complications at the time of confinement and the infant lived only one day. The other mother died of convulsions and uremic poisoning, giving birth to stillborn twins. As has previously been stated, these deaths might have been prevented, had adequate prenatal care been given."

A comparison of United States birth registration area statistics for five successive years with that of Woonsocket, for 1936 shows a five year average of

61.3 maternal deaths per 10,000 live births as compared with a five year average of Woonsocket, covering the same years with 57.6 maternal deaths per 10,000 live births. It is to be regretted that this improvement should be marred by an increase in the 1936 maternal mortality to 85 maternal deaths per 10,000 live births.

PRENATAL CARE

Many of the mothers in Woonsocket, do not seem to understand or attempt to realize the importance of adequate prenatal care. They often fail to realize the relationship between good prenatal care and its association with still birth and infant mortality.

In 1925, the cause of this neglect was laid to the large number of mothers of foreign birth in that there was considerable difficulty in urging them to understand proper prenatal care and to turn from old world ideas and customs of childbirth.

This makes a marked contrast to our present records. Examination of the nursing histories show that all mothers state that they have received prenatal care with three exceptions; all mothers gave histories of discontinuance of work before the sixth month of pregnancy.

No statistics are available to show at what period during pregnancy instruction is given, but it is felt by all authorities that the earlier instruction and care is given, the better chances the mother has for a successful termination of pregnancy.

From the records collected no Wassermann reactions are reported. This is unfortunate for here again we might have some clue that would be of aid to discover the causes for the number of stillbirths.

In the past the practice of taking a Wassermann on all pregnant women was not accepted as necessary, but at this date, with knowledge of the increase in the number of cases of syphilis and its effects upon the childbearing woman, it is an accepted policy that pregnant women should have a Wassermann, and that if it is positive, immediate treatment should be instituted.

However, it is felt that there is still a great need for education of the childbearing woman, in proper adequate prenatal care. Exercise, diet, proper clothing, refrain from long auto rides, surf bathing, dancing and other habits of our modern mothers are but a few of the causes for the precipitation in early pregnancy. It is unfortunate that the young pregnant women cannot, and in many cases will not be guided by the advice of her family physician.

In 1925, records showed that 33 mothers received no instruction whatever, and 61 mothers received advice from their physician.

Table VIII shows the age, nativity of mothers of stillborns, in Woonsocket, in 1925 compared with 1936.

TABLE VIII
AGE OF MOTHERS AT BIRTH, AND NATIONALITY OF MOTHERS — STILLBIRTHS IN WOONSOCKET FOR 1925 AND 1936

	1925	1936
Under 20	2	3
20-29	17	17
30-39	18	14
40 or over	7	6
	44	40
Native:		
Under 20	0	1
20-29	3	13
30-39	2	5
40 or over	1	3
	6	22
Native-Foreign Born:		
Under 20	2	2
20-29	7	3
30-39	7	5
40 or over	1	3
	17	13
Foreign Born:		
Under 20	0	....
20-29	7	1
30-39	9	4
40 or over	5	....
	21	5

It should be noted that 1936 was almost the reverse of 1925, in that most of the births are of native born women or native-foreign born parentage. The table also shows that most of the stillborn children were in women between the ages of 20 and 29 years of age.

TABLE IX
ORDER OF PREGNANCIES ENDING IN STILLBIRTHS FOR 1925 AND 1936

	1925	1936
First	14	16
Second	5	9
Third	3	3
Fourth	8	2
Fifth	3	2
Sixth	1	2
Over six	10	6
	44	40

Most of the stillbirths occurred in both studies during the first and second pregnancies. This is to be expected because of the lack of sufficient knowledge of the young wife. It is in this period progress must be made, and the extensive work carried out

in child hygiene by the United States Government, State and Local Medical societies, must manifest itself in this group.

Statistics show that the average time spent in bed during the postnatal period is 10 days.

Very little difference is noted in the mortality of stillbirth or infants according to sex for either 1925 or 1936. The greatest number of deaths occur in male children.

Economics

No attempt was made to correlate the low income group and the housing situation in Woonsocket, with the stillbirths and infant deaths. Strikes, low wages, failure to accept certain approved standards of living, unsettled labor conditions, poor housing, inadequate sunshine and ventilation in certain sections of the city, must receive proper attention. Statistics of such matters are difficult to obtain and even when obtained, the personal opinion of the investigator and the attitude of the family must be considered and at times are of very little or no practical value. Recent studies of relief groups show that the group as a whole contains a large number of persons with chronic illnesses or physical defects and who are susceptible to frequent attacks of illness.

A recent investigation of infant mortality[5] shows that 168 out of 1,000 babies born alive in families with a family income of less than $500 per year, died within a year. This rate decreased according to income, but shows that when the income was $3,000 per year or over, only 30 infants died per 1,000 live births. These figures are striking and could easily be applied to the statistics in Woonsocket.

Investigation of the United States Children's Bureau[6] has shown in infants under 1 year, a comparison of families whose income is $1,250 per year when compared to families whose income is $450 per year, that the mortality from gastro enteritis is seven times greater and deaths from respiratory diseases, five times greater in the second group, compared with the first.

Comment

Bundensun and his associates[7] in the recent study of infant mortality in Chicago give certain factors which they feel contribute greatly to infant deaths. They mention maternal complications, inadequate neonatal care and prematurity as some of the causes that should be considered. They state that early diagnosis and treatment of maternal complications are important to reduce the neonatal deaths. In their studies cerebral hemorrhage was the main cause of death when autopsies were performed compared with premature birth as the leading cause where autopsy was not performed. Emphasis is placed upon prompt attempts to resuscitate asphyxiated infants and adequate attention including the incubator for the premature child. They also consider the possibility of the relationship of better obstetrics to the administrationship of large amounts of vitamins B and D and Dicalcium phosphate.

It is evident that parents must be encouraged to develop a better understanding of the health needs of their children, and to seek better care for the expectant mother early in pregnancy. To develop a friendly feeling toward the family physician and to follow his directions carefully. The trend of the young married woman who finds herself pregnant to attempt to keep up with the rest of the "crowd" and to join in all forms of sports in order that she will not appear to be handicapped to her friends is to be regretted.

A more sane approach to motherhood and a proper normal approach to the termination of pregnancy is to be advocated. Fear of delivery and attempts at abortion because of present living conditions, and our present mode of living have much to do with our present high rate of stillbirth and infant mortality.

A definite educational program conducted, organized and set forth by the Woonsocket Medical Society, would do much to improve the present knowledge of our young mothers in what good obstetrics consist of. Advocation of medical care; early treatment in abnormal conditions, a Wassermann in every case of pregnancy, are but a few ideas that would work for the betterment of the obstetrical program in Woonsocket.

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NO PHYSICIAN ON THE HOSPITAL BOARD OF TRUSTEES?

In looking over the hospital field, we are surprised to find how many Boards of Trustees fail to have the physicians of the community represented. Is this an oversight or does the average board have some definite opposition to such representation? Is it felt that the physician lacks the necessary business acumen or may it be a fear that he will dominate the board and over emphasize the medical side of every problem?

True, the physician takes a different viewpoint from the average business man because his training is different and his business is different. He necessarily furnishes services and materials to people with no credit standing and he still furnishes these services with full knowledge that payment will never be forthcoming. But at the same time, he develops a profound knowledge of the medical needs of his community and a full realization of his obligations to his less fortunate fellowman.

A recent article bears the caption "In the Trustees lie our Strength." We believe that it is equally true that in our professional staff lies our strength. If the strength of the hospital lies in the two bodies, and we believe it does, then why shouldn't the Board of Trustees draw additional strength by making one or more members of the medical profession also members of the Board of Trustees?

Gone is the day when hospital trusteeship was chiefly a mark of distinction or an honor conferred upon the chosen few, a part that exacted little but gave much in social prestige and civic authority. The awakening of social responsibility is transferring hospital stewardship from an empty gesture to a definite job. In its ultimate realization lies the hope of the voluntary hospital. The result is an institution to which a sick individual may entrust himself with full assurance that nothing known to modern medical science will be left undone in the effort to safeguard his health and life.

The duties and responsibilities of the governing board of the hospital was defined by the American Hospital Association in 1924 as follows:

1. to determine the policies of the institution with relation to the community needs;
2. to see that proper professional standards are maintained in the care of the sick;
3. to coordinate the professional interests of the hospital with the administrative, financial and community needs;
4. to direct the administrative personnel of the hospital in order to carry out the policies and
5. to provide adequate financing both as to securing income and as to enforcing businesslike control of expenditure.

It would seem imperative that the members of the board upon whom such diverse duties fall should be chosen very carefully with the definite aim in view that any new member invited to join a board must possess characteristics or the type of mind which will be of value to the other members in the performance of these duties and responsibilities.

We believe that any well trained physician possesses these characteristics and would be of enormous value to a board in helping to formulate its policies and discharge its obligations to the community. We believe that while the staff should be represented by one or more physicians, the number should be kept small enough to preserve a normal balance in this body; that the physician or physicians chosen must not be members of the active staff, to prevent the possibility of having or being accused of having any personal axe to grind. To

fulfill this duty, he should be a physician who has had long active service that he may be well acquainted with the needs of the staff and the community and with the aims of the body he represents. He should make the ideal liaison officer between these bodies and be able to interpret the aims, needs and ideals of the staff to the management. Long experience as an active physician will enable him to discard the useless and choose the useful. He will give the staff a feeling of security, knowing that he has an intimate knowledge of their problems and sympathy for their aims, and will still be far enough removed from the actual activities to evaluate them dispassionately.

Can anyone suggest a better balanced Board of Trustees than a board comprised of ten or twelve successful business men, two physicians, an engineer, an architect, a real estate expert, a clergyman, an educator, a lawyer, and an expert accountant, all socially minded and willing and able to make a definite job of running a hospital?

SPECIALIZATION AND THE HOSPITAL

An ever increasing problem in the present state of specialization in medicine is that of the specialist treating conditions that do not properly fall within the field of his training. Examples of this are seen daily. It is impossible in many instances to draw sharp boundaries beyond which one should not go, but in many the limits are obviously and, frequently, disastrously over-reached.

The most pronounced offenders in this particular generally fall into one of two groups. The first group consists of those egotists who feel themselves capable of treating diseases in which they have had little or no preparation. It is a regrettable circumstance due to an all too frequent fallacy in the nature of man. In the present state of disorganization in medicine there is no satisfactory method of control. An appeal can only be made to conscience, which, unfortunately, tends to be present in inverse proportion to the severity of one's misdeeds. In the second group, generally younger men, are those whose practices are yet small and who feel the economic necessity of retaining patients that might better be treated by others. This condition is unfortunate for the doctor and for the patient. The doctor loses prestige in his profession and the patient loses the advantages of intelligent treatment.

Under the present system of medical economics, if it is a system, many of these who are dependent on their practice for financial support cannot remain strictly within their specialty and survive. Much of this could be obviated if doctors were paid for the large amount of work they do in charitable hospitals. Today much is being done and said for improving the standards of living. For people who are themselves unable to pay, moneys are provided for nearly all the necessities of life, including medicines and nursing care, and frequently for unnecessary luxuries. It is rare indeed that any money is provided for the doctor's attentions to the indigent sick within or outside the hospital.

It is becoming more and more apparent that it will be imperative for the doctor to be paid for his hospital work if the standards of non-academic medicine are to be maintained at a satisfactory level. He is so rushed with charity work along with his efforts to make a satisfactory living that he is unable to give his best to either endeavor. Already many capable young men are taking salaried positions with insurance companies, industrial firms and special institutions. They do this not so much because the work itself appeals to them but rather because they are assured of a livelihood without having to spread themselves thinly in unfamiliar fields at the start and to be too busy to be thorough when they are older.

If hospital services were headed by well-chosen, reasonably paid men, full time in some instances, part time in others, with lesser paid part time assistants, it would seem that the hospitals would be more efficiently run, the patient better served and the doctor freer to practice his profession without pinching so much for the elusive dollar. The saving made by more efficient management might well pay a good portion of the doctors' salaries. At the same time, if the problem were approached sincerely by those concerned, the destructive hand of politics could still be kept out of medicine.

Old News

Those who have dissected or inspected many bodies, have at least learned to doubt; when others, who are ignorant of anatomy and do not take the trouble to attend to it, are in no doubt at all.

Morgagni in "De sedibus et causis morborum," 1761, cited by Major in "Classic Descriptions of Disease."

RHODE ISLAND HOSPITAL

Clinical-Pathologic Conference

Tuesday, October 26, 1937

CASE PRESENTED BY
DR. BANICE FEINBERG

History: A nine months old Portuguese female infant was admitted to the pediatric service of the Rhode Island Hospital May 5, 1937 with failure to gain weight as the chief complaint.

The baby was born at home and weighed approximately 6¾ lbs. at birth. It was breast fed for three or four days and because of insufficient supply placed on an SMA feeding of 3 oz. every three hours, on which it has continued up to recently. It was never given cod liver oil. Has had about 1 oz. orange juice daily. The baby weighed fourteen lbs. at three months and still weighs the same. It always had regurgitated slightly after feedings. Lately the stools have been loose three or four times a day. Nose has "run all winter." "Running ear" from four to seven months of age.

Family History: Father and mother alive and well. No other pregnancies. No history of tuberculosis.

Physical Examination: Poorly nourished female infant. Head relatively large in proportion to body. Anterior fontanelle wider than normal. Sutures slightly separated. Face dusky, not cyanotic. No craniotabes. Eyes negative. Fundi negative. Ears—no discharge. Drums normal in appearance. Throat was injected. Posterior cervical and occipital lymph nodes enlarged. Chest negative save for moderate degree of beading of ribs, rachitic rosary. Heart negative. Spleen quite large and firm, lower pole extending down to level of umbilicus. Extremeties negative. No rigidity of muscles of neck or extremities. No Chvosteck, Trousseau or peroneal sign. There was a fine maculo-erythematous eruption over neck, shoulders and back.

Laboratory Data: Hemoglobin 76% 12.8 gms., Red Blood Cells 4,390,000 Anisocytosis 2 plus, Poikylocytosis 1 plus, Hypochromia 2 plus, Normablasts 0. White Blood Cells 7,850, Polymorphonuclears 56, Lymphocytes 32, Large Mononuclears 12, Eosinophiles 0, Basophiles 0.

Urine negative save for 1 plus albumen.

Blood Wassermann negative. Hinton positive.

The following morning temperature rose to 108 F. Patient cyanotic. Did not respond to oxygen or other therapy and died twenty-four hours after admission.

Additional Laboratory data: Lumbar puncture and splenic puncture ante mortem — Spinal fluid negative. No foam cells found on smear of splenic puncture.

Discharge Note: Malnourished female Portuguese infant nine months of age with hepato-splenomegaly and negative blood findings. Admitted in terminal state of a chronic disease.

Discussion

DR. HAROLD G. CALDER: "I have been asked to discuss this case from the standpoint of diagnosis.

The child died apparently from some terminal infection—probably bronchopneumonia, but he had a chronic disease extending over a period of 3 to 6 months. This was characterized by failure to gain weight, poor appetite, digestive disturbances and respiratory infections. The most striking feature is the enormous spleen and the differential diagnosis must consider the various causes of splenomegaly in infancy.

Chronic infections, especially tuberculosis and syphilis may cause an enlargement but never to this extent; nor are the other signs of these diseases present.

The various blood diseases, including nutritional (Von Jaksch) anemia, hemolytic anemia, leucemia are ruled out by the blood examination which shows only a mild secondary anemia.

Banti's disease may start in infancy. It is usually associated with vomiting of blood and if this does not cause death, the disease is quite chronic and lasts for years. It could not have the rapid downward course shown in this patient.

New growths of the spleen are possible but they are extremely rare. They would be expected to cause great loss of weight and cachexia rather than the extreme general weakness without loss of weight — which this case manifested.

We come next to the diseases characterized by disturbances of lipoid metabolism, in which lipoid or fatty material is deposited and stored in the cells of the body.

Gaucher's disease causes an enormous spleen, but it also causes bony changes and is very chronic. Patients live with it for many years and it does not cause death of itself.

Xanthomatosis also causes a large spleen but the changes in the bones, especially the skull, are more

noticeable. It occurs in childhood rather than infancy.

Niemann — Pick's disease is the third of this group. It occurs only in infancy. The patients are apparently healthy for a while — usually the first six months of life — when the appetite is lost and gains in weight stop. The beginning is quite insidious. Respiratory infections occur and general weakness becomes greater and greater. Examination shows a much enlarged spleen and liver. There may be also bony changes, a cherry red spot in the retina of the eye, and skin eruptions. The disease is always fatal and the course usually about six months. Death is preceded by some terminal infection. A positive diagnosis may be made by a biopsy of the sternal bone marrow, or by splenic puncture; and the demonstration of cells containing lipoid deposits.

In this case, the course is so typical that, with the other causes of splenomegaly ruled out, it is possible, even without a positive biopsy, to make a diagnosis of Niemann-Pick's dieases."

Postmortem Findings

Dr. Robert J. Williams: "Externally the body of the female infant was well developed but poorly nourished, measured 65 cm. in length and appeared to be 10 or 12 months in age. There were a few small palpable, discrete, firm nodes in the neck. When the peritoneal cavity was opened, the liver was seen to extend 6 cm. below the costal margin in the right mid-clavicular line and the inferior tip of the spleen extended to within 1.5 cm. of the crest of the ileum.

The organs of interest grossly are the spleen and liver, which we have here.

The spleen weighs 120 grams. The average weight of the spleen in a nine months old infant is 20 grams, so that the spleen in this case is at least six times the normal size. The spleen is large and firm and on section, shows a peculiar gray cast after the formalin fixation. The Malpighian corpuscles are not made out.

The liver weighs 550 grams — as compared to the average of 250 grams in a nine months old infant. It is large, pale, smooth and has a gray-yellow color. Cut surface bulges lobular markings.

The microscopic section of the spleen, stained with hematoxlin and eosin shows a very characteristic picture. There is diffuse and massive infiltration of the pulp cords by large mononuclear cells obliterating the sinusoids for the greater part. Only here and there are intact compressed sinusoids containing erythrocytes and lined by flattened endothelium. The follicles are small and in places, their central portion is occupied by the peculiar large mononuclear cells. Nowhere is there any suggestion of alveolar formation by these cells. The large mononuclear cells are round to polygnal in shape, average fifteen to thirty microns in diameter. The cytoplasm is minutely finely vacuolated, giving the cell a foamy appearance. The nucleus is round vesicular, nine to twelve microns in diameter, has a delicate nuclear membrane and fine dust-like scatterer chromatin particles. The cells usually contain only one nucleus, occasionally there are two to three nuclei. These cells have been termed lipoidphages.

The section of liver shows the liver cells to be swollen, compressing the sinusoids and the cytoplasm is filled with minute fine vacuoles. A few lipoidphages are present between the liver cords.

Sections of lung show the alveolar and bronchial spaces to be filled with the lipoidphages and also the interstitial tissue is slightly infiltrated.

In addition, sections of lymphnode, bone marrow, thymus show more or less infiltration by the lipoidphages and the ganglion cells of the brain show a minutely finely vacuolated cytoplasm.

The above findings are quite characteristic of "Niemann-Pick's Disease," Essential Lipoid Histiocytosis.

Review of Literature

Dr. Stanley Freedman: "In 1914 Niemann of Berlin, Germany, described for the first time a case which he labeled "An Unknown Disease Picture." This case had marked pallor, enlargement of the liver and spleen, abdominal distention and ascites. Its course was progressive and it terminated fatally in a few weeks.

A few years later Pick, also of Germany, undertook a systematic study not only of the condition described of Niemann, but also of a number of related diseases, all of which have a common feature —namely a disturbance in lipoid metabolism. These diseases are now known as the Xanthomatoses. As a result of further observations, and as a result of the discovery of more cases, the classical description which Niemann gave in 1914 has now emerged into a definite entity which is known as Niemann-Pick's disease. It begins in the first few months of life. It is congenital and malilial. It terminates

fatally before the child is two years old. Knowing the age at which it strikes it could be diagnosed almost at its incipiency.

In spite of the extensive studies recently made on this subject, little has been added to Niemann's original description. He even described the so-called foam cells which you saw on the slides of our case. The substance in these foam cells is now known to consist of cholesterol and phosphatids.

The original controversy as to whether the disease represents a disturbed lipoid metabolism, or is neoplastic in nature, still exists.

Originally also the disease was thought to exist only in children of the Jewish race. This is not so, as some of the reported cases occurred in English, Irish and other nationalities. The preponderance of cases, of which sixteen had been reported up to 1932, are unmistakably in Jewish children."

RHODE ISLAND MEDICAL SOCIETY

Meeting of the Council

The regular meeting of the Council was held on Jan. 20, 1938 at the Medical Library, and was called to order by the President, Dr. Walter C. Rocheleau, at 4 P. M.

There were present Doctors Rocheleau, Mowry, Wells, Hammond, Partridge, Donley, Young, Miller, Gormly, Arthur Jones, Holt, and DeWolf. It was voted to omit the reading of the minutes of the Council meeting held Nov. 19, 1937 since it had already been published.

Dr. Mowry then presented the annual budget for 1938, and on motion by Dr. Hammond, seconded by Dr. Partridge, it was voted to accept the report and place it on file. Dr. Mowry read the annual financial report of the Rhode Island Medical Journal for 1937, and on motion made and seconded, it was received and placed on file.

Resignation of Dr. James O'Hear, Jr. was read by Dr. Mowry, and it was voted to accept same. The following Fellows were placed on the retired list after same was duly moved and seconded: Dr. D. F. Gray, Dr. M. B. Milan and Dr. J. F. Hawkins.

Dr. Virgilio M. Bertone's application for reinstatement was presented, and it was voted that he be reinstated after paying four years dues, and dues for the coming year. It was moved and seconded that Dr. Fenwick be dropped for non-payment of dues.

On motion by Dr. Miller, seconded by Dr. Donley, it was voted that we not join the New England Council. Dr. Miller spoke on the state of the Rhode Island Medical Journal, and made the following motion:

> "1st. That the Council recommend that a committee of the House of Delegates consider the question of the expense of the annual dinner, making a charge for the annual dinner to those who consume it, and a corresponding reduction in the annual dues.
>
> 2nd. That the sum of $984.00, this being $2.00 for each of the 492 members, be appropriated for support of the Medical Journal!"

The motion was amended that a committee be appointed, Dr. Miller being a member, to study the motion and report back to the Council as soon as possible.

Adjourned,
Respectfully submitted,
GUY W. WELLS, M.D.,
Secretary

Meeting of the House of Delegates

The regular meeting of the House of Delegates was held Jan. 20, 1938 at the Medical Library, and was called to order by the President, Dr. Walter C. Rocheleau, at 4:30 P. M. The report of the Council meeting held immediately preceding this meeting was read by the Secretary, and upon motion made and seconded it was voted to accept same and place it on file. The Treasurer, Dr. J. E. Mowry, then read in detail the budget for 1938, and the financial report of the Medical Journal. It was voted to accept these reports and place same on file. Upon motion being made, and duly seconded, it was voted to fix the dues for the year at $10.00.

The President then read the deaths which have occurred since the annual meeting, and referred these to the Committee on Necrology for action in June:

Henry Ecroyd	died June 4, 1937
J. E. F. Henry	died July 6, 1937
Chas. W. Higgins	died Aug. 19, 1937
Harvey E. Wellman	died Oct. 24, 1937
Emery P. Sweet	died Nov. 23, 1937
Wm. C. McLaughlin	died Dec. 6, 1937

The following appointments were made by the President. Delegates to the New England Medical Societies:

Maine:
Dr. G. G. Dupre, Woonsocket
Dr. Wm. Cutts, Providence
New Hampshire:
Dr. A. Fontaine, Woonsocket
Dr. F. H. Chafee, Providence
Vermont:
Dr. Lorenzo H. Emidy, Woonsocket
Dr. George Young, East Greenwich
Massachusetts:
Dr. Morgan Cutts, Providence
Dr. T. A. Krolicki, Pawtucket
Connecticut:
Dr. Linwood Johnson, Westerly
Dr. John Helfrich, Westerly

Appointment of member at large of the Board of Trustees of the Library Building:
Dr. J. F. Archambault, West Warwick

Appointment of Anniversary Chairman:
Dr. Frank Kennedy, Woonsocket

The nominating Committee for 1938:
Dr. R. Hammond, Providence
Dr. John F. Kenney, Pawtucket
Dr. Wm. S. Streker, Providence
Dr. Henri E. Gauthier, Woonsocket
Dr. H. P. Gongaware, Hope Valley

Committee on Annual Clinics: the same as last year:
Dr. C. O. Cooke, Providence
Dr. D. L. Richardson, Providence
Dr. J. F. Kenney, Pawtucket
Dr. F. E. McEvoy, Providence
Dr. R. Whitmarsh, Providence
Dr. B. H. Buxton, Providence
Dr. A. H. Ruggles, Providence
Dr. A. H. Miller, Providence

Committee on Annual Commercial Exhibits: the same as last year:
Dr. C. W. Skelton, Providence
Dr. B. H. Buxton, Providence
The Treasurer, ex-officio

New Business:

Dr. Wells suggested that the Committee on Medical Defense be changed to Committee on Medical Defense and Grievance, enlarging the power of the Medical Defense Committee, and to include controversial subjects.

Dr. Gormly stated that the Providence Medical Association has already a Committee on Deportment and Ethics, and that Woonsocket, Pawtucket, and Kent have a similar committee, but as yet he has not been able to get such a committee working in the Newport or Washington Societies. The intention or purpose is to have each district society organize such a committee, and eventually have the Rhode Island Medical Society its mother committee. These committees have to do with the question of malpractice, or questions on ethics and deportment. The Medical Defense Committee was appointed to work in conjunction with the United States Fidelity and Guaranty Co. with reference to the Group Insurance, and Dr. Gormly felt it was not wise to change this committee, but to appoint a new committee on grievances.

Dr. Burgess moved that a committee of seven be appointed on the question of Grievances, and being duly seconded it was so voted.

Dr. Gormly stated that the Medical Director of the SUR was desirous of meeting with the Committee on Medical Emergency Relief that was in existence in the year 1935-1936 but which had not been functioning to any great extent, and of which he was chairman. Referring to this committee, the president re-appointed the same committee to carry on, and to meet with the Medical Director as requested.

Dr. Chas. F. Gormly, Providence
Dr. W. P. Buffum, Providence
Dr. M. H. Scanlon, Westerly
Dr. N. M. MacLeod, Newport
Dr. Stanley Sprague, Pawtucket
Dr. H. E. Gauthier, Woonsocket
Dr. C. S. Christie, West Warwick

Dr. Miller spoke in regard to appointing a committee to consider the expense of the annual dinner with reference to his motion made to the Council. He stated that most State Societies appropriate a sum to carry on their Journal, and suggested that the Publication Committee be allowed to draw amounts needed out of the sum, or the whole amount, and refund at the end of the year. Dr. Miller asked for suggestions, and Dr. Gormly stated he thought that it would be better, as Dr. Miller suggested, to make the Journal more worthwhile, and make the annual meeting a real scientific one.

Dr. Burgess moved that a committee of five be appointed to consider Dr. Miller's motion with regard to the expense of the annual dinner as presented to the Council. Being duly seconded it was carried. This committee to report as soon as possible.

Dr. Kingman was in accord with Dr. Miller with reference to the Journal.

Adjourned

Respectfully submitted,

GUY W. WELLS, M.D.,
Secretary.

PROVIDENCE MEDICAL ASSOCIATION

January Meeting

The Annual Meeting of the Providence Medical Association was called to order by the President, Dr. Peter Pineo Chase, on Monday, January 3, 1938 at 8:45 P. M.

The minutes of the last meeting were read and approved. The Annual reports of the Secretary, Treasurer, Standing Committee, and Reading Room Committee were read and it was voted that they be accepted. The President then delivered his annual address in which he dealt with the problem of cancer and its control.

After the President's address, the following officers and committees were elected for the year 1938:

President—Alex. M. Burgess, M.D.

Vice-President—Harry C. Messinger, M.D.

Secretary—Herman A. Lawson, M.D.

Treasurer—William P. Davis, M.D.

Members of the Standing Committee — Peter Pineo Chase, Louis I. Kramer (5 years); Joseph L. Belliotti (3 years); Robert H. Whitmarsh (3 years); James H. Fagan (2 years); Frank B. Cutts (1 year).

Trustee — R. I. Medical Lib. — Lucius C. Kingman (1 year).

Reading Committee — Albert H. Jackvony, Andrew Mahoney, Henry L. C. Weyler.

Delegates to the House of Delegates of the R. I. Medical Society — W. C. Gordon, W. M. Muncy, J. J. McCaffrey, C. B. Leech, A. J. Pedorella, J. M. Beardsley, C. R. Doten, H. J. Gallagher, N. A. Bolotow, Jos. Franklin, Chas. Bradley, W. S. Streker, H. A. Lawson, J. P. Eddy, 3d, D. V. Troppoli, M. Adelman, F. Ronchese, A. M. Burgess, G. F. White, M. Saklad, J. A. Hayward, H. C. Messinger, E. Wade Bishop, Charles L. Southey and Henry McCusker.

Dr. Edward D. Churchill, John Homans Professor of Surgery, Harvard Medical School, delivered a paper entitled "Primary Cancer of the Lung." Following Dr. Churchill's paper, Dr. W. S. Streker reported for the Standing Committee regarding the employment of an executive secretary. He discussed this matter at length and made a suggestion that dues for the year 1938 be increased to $15.00. After considerable discussion is was so voted.

The new President, Dr. Alex M. Burgess, then announced the following appointments to committees:

Medical Milk Commission—Dr. Halsey DeWolf and Dr. A. R. Newsam, appointed for five years to replace Dr. F. B. Corrigan and Dr. William Hindle whose terms have expired.

Committee on Ethics and Deportment—To replace Dr. M. S. Danforth and Dr. L. C. Kingman whose terms have expired, Dr. George VanBenschoten and Dr. A. A. Barrows.

Public Relations Committee — To replace Dr. A. M. Burgess, Dr. Louis I. Kramer and Dr. J. L. Belliotti, Dr. N. Bolotow, Dr. William Mahoney and Dr. Cecil C. Dustin.

Collation Committee — To replace Dr. Clarence Reilly, Dr. Jacob Warren.

Advisory Committee to the Bureau for the Handicapped—To replace Dr. Harvey E. Wellman, deceased, Dr. John C. Ham.

Dr. Ira H. Noyes read an obituary of the late Dr. David Brodsky and the Secretary read an obituary of the late Dr. Emery P. Sweet. It was voted that these be spread on the records and that copies be sent to the families and to the Rhode Island Medical Journal.

The following appropriations were voted:

for the use of the Library building	$450
for binding periodicals	$250
for subscriptions to Medical Journals	$250

The meeting adjourned at 11:10 P. M.

Attendance 152 — Collation was served.

Respectfully submitted,

HERMAN A. LAWSON, M.D., *Secretary.*

Annual Report of the Standing Committee

The Standing Committee of the Providence Medical Association has held eight meetings during the year 1937. Thirty applications for membership were considered and twenty-four were approved.

On March 25, 1937, a special meeting was held at which the roentgenologists in Providence doing private practice and the Rhode Island Director of Public Health were present to consider the matter of X-ray examinations of industrial employees and food handlers. Certain proposals for handling these matters were drawn up by the X-ray specialists and presented to the Standing Committee. These proposals together with a report for a special committee of the Standing Committee were read at the regular meeting of the Association held on June 7, 1937.

Respectfully submitted,

HERMAN A. LAWSON, M.D., *Secretary.*

Annual Report of the Secretary

The Providence Medical Association has held nine meetings during the year 1937. Twenty-five new members have been elected. The Association has lost thirteen through death and four members by resignation. One member has been dropped for

non-payment of dues. The membership of the Association at the end of the year, therefore, numbered 508, a net increase of five over 1936.

At the regular monthly meeting held on November 1, 1937 the By-Laws were amended to provide for an enlarged Standing Committee which shall hereafter consist of the President, Vice-President, Secretary, and Treasurer, ex-officio, and ten members of the Society instead of five as heretofore. At the same meeting the By-Laws were amended to authorize the Standing Committee to employ an executive secretary whose salary and expenses of office shall be fixed within the appropriation voted by the Association for this purpose.

On February 24, 1937, the Association lost through the death of Dr. Charles F. Deacon, a faithful and efficient officer, who had been Treasurer of this organization for many years. The President appointed Dr. William P. Davis, Treasurer, to complete the unexpired term of Dr. Deacon.

Respectfully submitted,
HERMAN A. LAWSON, M.D., *Secretary.*

Report of the Blood Transfusion Bureau

The President
Providence Medical Association

The report of the Blood Transfusion Bureau is as follows:

The beginning of the fiscal year, with the permission of the President of the Association, was changed from January 1, to October 1. Therefore, this report only covers the first nine months of 1937.

Donors were provided for eighty-two transfusions, an increase of three over the preceding twelve months. Seventeen of these were for charity cases. $215.50 was dispersed from the Charity Fund in partial or total payment. There were forty-nine paying cases, yielding an income for the year of $122.50. The expenses amounted to $15.75, leaving a net income of $106.75.

The committee is again pleased to report a contribution to the Charity Fund of $25.00 from the Mary Dexter Fund, Incorporated. At the present time, we have been turning our profit back into the Charity Fund.

The Bureau appears to be a self-supporting institution and from the fact that more donors are being called every month, we may say that it is filling a genuine need in the community.

Respectfully submitted,
FRANCIS H. CHAFEE, M.D.,
Chairman and Treasurer.

WOONSOCKET DISTRICT MEDICAL SOCIETY

January Meeting

The Woonsocket District Medical Society held its January meeting at LaMartinique on the first Tuesday of the month. In keeping with the traditions of later years, supper was enjoyed by more than thirty-five members. The speakers of the evening was Dennette Adams of Boston. His paper was entitled "Gastric Neuroses."

PAWTUCKET MEDICAL ASSOCIATION

Minutes of the December Meeting

The regular meeting of the Pawtucket Medical Association was held at the Pawtucket Memorial Hospital, December 16th, 1937.

The President, Dr. E. A. Cormier, presided.

The following suggestions of the Standing Committee were voted on and passed: (1) That the Library Committee be eliminated. (2) That the by-law tying the local with state dues be eliminated. (3) That the fiscal year begin in January. (4) That the dues accompany the application of every applicant for membership. It was voted that the Pawtucket Medical Association donate $25.00 to the Memorial Hospital of Pawtucket.

Dr. Vincent J. Ryan, the guest speaker of the evening, presented lantern slides on "Common Skin Diseases." Thirty members attended. Collation was served.

Respectfully submitted,
THAD A. KROLICKI, M.D., *Secretary.*

Minutes of the January Meeting

The regular meeting was held at the Memorial Hospital on January 20, 1938. The minutes of the previous meeting were read and approved. Numerous communications were read. Dr. R. Lussier and Dr. A. Melluci were elected regular members of the Association. The president appointed the following committees:

1. Banquet Committee
   Dr. S. Sprague, *Chairman*
   Dr. Rob. Henry
   Dr. E. Trainor.
2. Nominating Committee
   Dr. C. H. Holt, *Chairman*
   Dr. Earl Kelly
   Dr. H. J. Hanley

Dr. Stanley Sprague presented a paper on "Urological Observations in Diabetes." Twenty-five members and five guests attended. Collation was served.

Respectfully submitted,
THAD A. KROLICKI, *M.D., Secretary.*

LOCAL EVENTS

February 8.

Dr. Frank T. Fulton entertained the Amos Throop Medical Club. He presented a case of auricular flutter in a three months old child, successfully treated with large doses of digitalis. The paper was discussed by Drs. John C. Ham, Henry E. Utter, Guy W. Wells, and by members of the club.

February 10.

At the monthly meeting of St. Joseph's Hospital Staff Association, a paper on "Allergy, with special reference to Bronchial Asthma in the Adult and in the Child," was presented by Drs. Frederick R. Riley and Stanley S. Freedman. Collation was served.

February 15.

At the regular meeting of the General Staff of the Homeopathic Hospital of Rhode Island, Dr. Harrison F. Hyer read a paper on "Cardiac Neurosis." Luncheon was served.

Officers for the ensuing year were elected as follows: *President,* Dr. Harrison F. Hyer; *Vice-President,* Dr. Joseph A. Beaute; *Secretary-Treasurer,* Dr. Louis D. Lippitt; *Executive Committee,* Drs. William M. Muncy, James H. Prior, Ralph W. Hayman, Edmund A. Sayer, Harold L. Collom.

February 18.

The Friday Night Medical Club was entertained by Dr. Lucius C. Kingman. He presented a paper on "Post-Graduate Surgical Instruction." Announcement was made of the election of Dr. Elihu S. Wing as a member of the club.

February 19.

Dr. Nathan A. Bolotow attended the mid-year Convocation of the University of Pennsylvania. He was awarded the degree of Master of Medical Science for graduate work in otolaryngology. The subject of Dr. Bolotow's thesis was "The Radical Mastoid Operation in the Treatment of Chronic Suppuration of the Temporal Bone."

Memorial Hospital

At the clinical pathological conference, held February 9, a case was presented from the surgical service by Dr. William P. Davis and discussed by the staff. The points brought out were the diagnosis and differential diagnosis in carcinoma of the pancreas. The medical service presented a review of the pneumonia cases treated with serum to date in the hospital.

The officers elected for the staff at this meeting were: Dr. John F. Kenney, President; Dr. Earl F. Kelly, Vice-President; Dr. Stanley Sprague, Secretary; Dr. Robert T. Henry, Treasurer.

Dr. Earl F. Kelly is vacationing in Florida.

The Memorial Hospital has received a sizable sum of money to establish a sero-bacteriological department to be known as the Manning Heffern Memorial.

CHANGE OF ADDRESS

Dr. John F. Kenney is changing his office from 206 Broadway to 209 Broadway, Pawtucket, R. I.

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

The general oral, clinical and pathological examinations for all candidates (Groups A and B) will be conducted by the entire Board, meeting in San Francisco, California, on June 13 and 14, immediately prior to the meeting of the American Medical Association. Application for admission to the June Group A examinations must be on an official application form and filed in the Secretary's Office before April 1. The annual informal Dinner and General Meeting of the Board will be held at the Palace Hotel, San Francisco, on Wednesday evening, June 15, at seven o'clock. Dr. William D. Cutter, Secretary of the Council on Medical Education and Hospitals of the American Medical Association will be the guest speaker, and the Diplomates certified at the preceding days' examinations will be introduced individually. All Diplomates are invited to attend the dinner meeting, and to bring as guests their wives and any persons interested in the work of the Board. For further information and application blanks address Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburgh (6).

St. Joseph's Hospital

During the past year, the organization and establishment of several special clinics has been carried through at the Hospital. The clinics are as follows:

1. Goitre Clinic, in charge of Dr. Frank E. McEvoy.
2. Hematology Clinic: This Clinic for the special study of blood dycrasias is newly organized under the Medical Department and is to be in charge of Dr. John C. Corrigan of Fall River, Massachusetts.
3. Allergic Clinic: This Clinic operating also as a division of the Medical Department, has been carrying on its work throughout the year; as also has the Diabetic Clinic under the same arrangement.
4. Tumor Clinic: Development of the clinic manned by members of the Staff, has been carried through to start functioning at the first of this year. The Hospital has installed the latest type of x-ray equipment for giving deep therapy and has acquired radium also to be used as will be required by this new development. The Tumor Clinic is to be held each Friday at 11 A. M. All Staff members and interested physicians are welcome to visit at any time.

The monthly meetings are to be continued as usual on the second Thursday of each month. Clinical Conferences are at 12 o'clock Noon on Fridays.

Dr. Arnold B. Moore, who has recently completed a two year rotating internship and a residency in Obstetrics, has opened his office at 588 Howard Avenue, New Haven, Connecticut.

Woonsocket Hospital

The monthly Clinico-pathological conference was held on January 24, 1938. Dr. Walter C. Rocheleau presented a case of Aneurysm of the Abdominal Aorta. The autopsy findings revealed the presence of a long standing aneurysm with rupture occurring a few days before death. A second case was presented by Dr. Henri E. Gauthier a recent case of Melano-Sarcoma of the Lumbar region. Rapid generalized metastases were confirmed by autopsy. General discussion followed the presentation of each case.

Rhode Island Hospital

SCHEDULE FOR MARCH, 1938

Thursday, March 3, 1938:
Gyn. Staff Meeting, 8:30 P. M.
Friday, March 4, 1938:
G. U. Staff Meeting, 7:30 P. M.
Surg. Staff Meeting, 8:30 P. M.
Tuesday, March 8, 1938:
Clinical Path. Conference, 12:00 noon.
Tuesday, March 22, 1938:
Clinical Path. Conference, 12:00 noon.
Mondays:
Surgical Grand Rounds, 10:00 A. M.
I Surg. Grand Rounds, March 14, 28.
II Surg. Grand Rounds, March 7, 21.
Skin Clinic at O.P.D., 11:30 A.M.
Thoracic Clinic, 4:30 P. M.
Tuesdays:
Gastro-Intestinal Clinic, 9:30 A. M.
Surgical Grand Rounds, 10:00 A. M.
I Surg. Grand Rounds, March 8, 22.
II Surg. Grand Rounds, March 1, 15, 29.
Wednesdays:
Tumor Clinic, 10:00 A. M.
Thursdays:
Orthopedic Grand Rounds, 9:00 A. M.
Thoracic Clinic, 11:30 A. M.
Fridays:
Fracture Grand Rounds, 11:00 A. M.
Pediatric Grand Rounds, March 11, 25, 11:00 A. M.
Skin Clinic at O.P.D., 11:30 A. M.
Saturdays:
Neurological Grand Rounds, 9:00 A. M.
Medical Conference, 10:00 A. M.

On January 15th, Dr. Daniel C. Hackett started a two years' internship. Dr. Hackett, whose home is in Riverdale, N. Y., is a graduate of Williams College and Columbia University, College of Physicians and Surgeons.

On January 29th, Dr. Ralph Purvine, who interned at the Rhode Island Hospital for two years, left for his home in Salem, Oregon. Dr. Purvine travelled by automobile. On the way, he spent one night at the home of Dr. and Mrs. Luther McDougal in Paris, Texas. Dr. Purvine is a graduate of Willemette College and Jefferson Medical School. He expects to return to Providence, April 1st.

On December 24th, 1937, at Cambridge, Mass., Dr. Charles S. Bryan, intern at the Rhode Island Hospital, was married to Miss Mary Marks, of Minneapolis, Minn. At present, Mrs. Bryan is residing in Cambridge, Mass.

Dr. Stephen H. Harris, who interned at the Rhode Island Hospital from October 15, 1935, to November 1, 1937, and who spent some months at the Chapin Hospital, is now stationed at Fort Ethan Allen, Vermont.

On February 1st, Dr. George E. Bowles started a six months' internship at the Lying-In Hospital. Dr. Bowles was recently a patient in Ward F.

Dr. Reeve Betts, who has been associated with the Lahey Clinic in Boston, has resigned and is now associated in practice with Dr. Overholt at 1101 Beacon Street, Boston, Mass.

Dr. Edmond B. Sinclair, of Providence, has begun his service as Resident Physician at the Jane Brown Memorial Hospital. Dr. Sinclair was intern for two years at the Rhode Island Hospital. He is a graduate of Brown University and Yale Medical School.

On February 15th, Dr. Walter Fitzpatrick, of Providence, a graduate of Providence College and Georgetown Medical School, began a two year internship at the Rhode Island Hospital.

On January 15th, Dr. John S. Dziob completed his year of residency at the Jane Brown Memorial Hospital and has now entered private practice at 184 Waterman Street, Providence.

OBITUARY

CHARLES WESLEY HIGGINS, M.D.

Dr. Charles Wesley Higgins, prominent general practitioner and gynecologist in Providence, died quietly in his sleep on August 19, 1937. He was in his seventy-second year. Dr. Higgins was born in Wellfleet, Massachusetts, August 3, 1866. After attending public schools in Providence, he studied pharmacy. Working as a pharmacist, he began the study of medicine and graduated from the Medical School of the University of Pennsylvania in 1894. After two years internship at the Rhode Island Hospital, he commenced private practice in Providence in 1896. Soon he was appointed to the gynecological staff of the Rhode Island Hospital, with which he was connected throughout his life, being at his death the senior consulting surgeon in that department. He served as house physician at the Providence Lying-In Hospital from 1897 to 1899, and as visiting physician for the next fourteen years, after which he continued as a member of the consulting staff. He was for many years consulting surgeon to the South County Hospital. In 1904, he married Evangeline M. Spring of Worcester, Massachusetts, who survives him.

Dr. Higgins early became prominent in private and in hospital work and continued in the fore front in medical and surgical circles throughout the years. While he continued to do general practice, his work in obstetrics and gynecology constituted a large part of his practice. His surgical judgment and operative skill earned for him the high regard of his colleagues and of the public. He was a man of high ethical medical standards and such engaging personality as to win for him the warm friendship and high esteem of all who knew him. Among these he will be greatly missed and his passing will be deeply regretted.

GEORGE L. SHATTUCK, M.D.
HALSEY DEWOLF, M.D.

DAVID R. BRODSKY, M.D.

David R. Brodsky was born in Russia, December 25th, 1903, coming to this country with his parents when two years old. He attended the primary schools in Providence and was graduated from Hope Street High School in 1921. The following year he entered Brown University and received his Ph.B. degree with the class of 1925. He received his medical education at Tufts College Medical School where he was awarded his medical degree in 1929. His clinical experience began at the Memorial Hospital, Pawtucket, where he served a rotating internship for one year. Having chosen Gynecology and Obstetrics as a field of medical practice, he took an appointment at the Carney Hospital in Boston for eighteen months, preparing himself for his specialty. This work was supplemented by six months of obstetrical training at the Providence Lying-In Hospital which he ended in February 1932.

In April 1932 he opened his office for the practice of Gynecology and Obstetrics in Providence. He became assistant surgeon in the department of Gynecology and Obstetrics of the Miriam Hospital and visiting surgeon in Gynecology to the outpatient department of the Charles V. Chapin Hospital. He was a member of the associate staffs of the Homeopathic and Lying-in Hospitals.

He was a member of the Providence Medical Association, Rhode Island Medical Society, American Medical Association and the New England Obstetrical and Gynecological Society.

Although Dr. Brodsky had been in actual private practice for a comparatively short time, he had already established himself as a capable physician with a large and loyal following. In the course of a prolonged illness, his fortitude and perseverance were of unbelievable magnitude. In the face of the inevitable, he continued his work smilingly and diligently, knowing all the time that his days of labor were to be but brief and numbered. He spent his last days in hope that he might still recuperate enough to return again to the demands of his practice. He was on the threshold of life, with a brilliant future ahead of him in his chosen specialty. His associates and his host of friends grieve at his premature passing. Death occurred on December 11, 1937 at the Beth Israel Hospital in Boston. Burial took place at Lincoln Park Cemetery, Warwick, R. I.

Dr. Brodsky is survived by a most devoted wife, Fredda (Fishman) Brodsky and a son, Leonard Fischer Brodsky.

IRA H. NOYES, M.D.
NATHAN A. BOLOTOW, M.D.

EMERY PECKHAM SWEET, M.D.

Dr. Emery Peckham Sweet was born November 6, 1864, died November 23, 1937.

He was a member of one of Rhode Island's oldest families. His first ancestor was James Sweet who settled on Prudence Island in the Seventeenth century. His father was Dr. Thomas Sweet.

Dr. Sweet graduated from College of Physicians and Surgeons in New York, the Medical Department of Columbia University, in 1889, with a degree of Doctor of Medicine. Immediately after graduation he started practice in Providence, having his office in the old Butler Exchange Building and later in The Union Trust Building.

In his earlier years he was a general practitioner of medicine and surgery; in later years he limited his work more to joint and bone disturbances. Because of increasing ill-health he gave up the practice of medicine about two years ago and for the past year he had been completely disabled as the result of a cerebral hemorrhage.

He was quite prominent in fraternal orders and was a 32nd degree Mason. He was very kind and sympathetic and was much beloved by his patients.

On October 7, 1891 Dr. Sweet was married to Miss Laura Bishop Rogers of Providence. They had no children. He is survived by Mrs. Sweet and his sister, Mrs. Herbert E. Hathaway of Detroit, Michigan.

JAY PERKINS, M.D.

RECENT BOOKS

SHORT-WAVE DIATHERMY. By Tober de Cholnoky, M.D., F.A.C.S. Pp. 310, with 38 illustrations. Cloth, $4.00. The Columbia University Press, New York, 1937.

Heat therapy has received much notice recently because of various electrical methods of generating heat in the body. This book limits itself to the consideration of heat production by electrical waves of 3-30 meters or a frequency of 10-100 million per second. Conventional or long wave diathermy employs wave lengths of 300-600 meters or frequencies of 0.5-1.0 million per second. The advantages claimed for short wave diathermy are, more even heat production and deeper penetration; together with the lack of necessity for direct body contact of electrodes and hence less danger of accidental burns through displacement of electrodes.

The author gives a simple, but adequate explanation of the physics of short wave generators, followed by an extensive review of experimental work both in vivo and in vitro. Technic in general is discussed, followed by detailed discussion of indications in various diseases and areas of the body. This section on clinical applications occupies about one-third of the volume. The book concludes with an extensive bibliography which takes up nearly forty pages.

The work presents the enthusiastic but well considered views of the author on the subject, and avoids the attitude that diathermy is a "cure-all" in spite of widespread indications for its use. Possible specific effects of short wave radiations are discussed but in the concluding chapter he says: "At present, short wave diathermy may be considered purely a form of heat therapy. . . . The chief beneficial action seems to be the induction of an intense and lasting hyperemia."

The book may be studied with profit, by anyone interested in the subject.

PHILIP BATCHELDER, M.D.

THE MANAGEMENT OF FRACTURES, DISLOCATIONS AND SPRAINS. By John Albert Kay, B.S., M.D., and H. Earle Conwell, M.D., F.A.C.S. Second Edition, pp. 1246, with many original illustrations, Cloth, $12.50, The C. V. Mosby Company, St. Louis, 1937.

This book is a revised edition of the excellent volume published in 1934. The methods of treatment of fractures are changing so rapidly that text-books require frequent

revamping. To illustrate: in this new edition the authors recommend that a fracture of the carpal scaphoid be immobilized in plaster

> "... with the hand at the wrist moderately hyperextended and fully abducted; that is, deviated to the radial side. The thumb is fully adducted and extended."

while in the 1934 edition the same fracture is held in plaster

> "... with the hand at the wrist in the mid-position as regards flexion and extension and slightly adducted; that is, deviated to the ulnar side. . . . The thumb is in the grasping position (adducted and opposed) . . ."

It is through such reversals that real progress is made in the treatment of fractures. Likewise the treatment of femoral neck fractures has changed considerably since 1934—from open reduction and insertion of the Smith-Peterson nail to the simpler Leadbetter, or closed, reduction and the insertion of nails or pins through small incisions and under X-ray guidance. In this edition the authors have added concise descriptions of the various methods of nailing and spiking these fractures of the neck of the femur, such as the Smith-Peterson-Johanssen nail technic, the Austin Moore method of inserting three threaded pins, the O'Meara method of "blind" nailing, and other modifications of these methods. The reproductions of the X-ray plates to illustrate these methods are particularly well done, in fact, the illustrations throughout the book are unusually clear and well chosen. This volume accomplishes its avowed purpose "to furnish a practical working guide in the management of fractures, dislocations, and sprains."

To surgeons and orthopaedists who treat many fractures and dislocations this new edition should be especially helpful. To practitioners who treat these cases occasionally this book is a real necessity, both because of the up-to-the-minute methods advocated and to avoid mal-practice threats. For interns and medical students it is a reliable source of reference.

HENRY MCCUSKER, M.D.

OBSTETRIC AND GYNECOLOGIC NURSING. By Frederick H. Falls, M.S., M.D., F.A.C.S., and Jane R. McLaughlin, B.A., R.N., pp. 492, with 83 illustrations. Cloth, $3.00. The C. V. Mosby Company, St. Louis, 1937.

This is a book of 490 pages, divided into 34 chapters. It is written for pupils who have a rather advanced knowledge of general nursing principles and goes into the specific field of Obstetrics and Gynecology exhaustively. While the authors have not lost sight of the fact that bedside nursing ability and the direct care of the patient is the primary work of the graduate nurse, the amount of theoretical material such as physiology, pathology and bacteriology seems rather overwhelming for the average pupil nurse. One ponders on why a nurse should be much concerned with the details of classification and measurements of deformed and contracted pelves, or what occasion she has for studying the technique of such procedures as Craniotomy, Decapitation, Embryotomy or Pubiotomy. It would seem doubtful if even those unusually efficient nurses of the Frontier Nursing Service ever are required to perform such special technical work.

Of course the inclusion of so much theory as now appears in textbooks for nursing harks back to the general standards of nursing education and the immense amount of material that a nurse is required to retain long enough to pass a State board examination, and one who does considerable work in Obstetrics and Gynecology cannot help but sometimes wish for simpler ways in training nurses in the sympathetic, gentle, kindly homely care of a sick or convalescing bed patient, rather than overburdening her time and strength and mind with Medical and Surgical Problems of Technique and Treatment which will always lie entirely in the field of the Doctor of Medicine.

Incidentally, although this work goes into considerable detail as to contracted pelves, no mention is made of the present day accepted classification of Caldwell & Malloy or of Radiographic study of pelves. One also might take issue with some of the rather obsolete treatments advised in this comprehensive textbook, such as Quinine and Castor Oil for the Induction of Labor, and "How to make and apply hot wet dressings for 'Milk Leg'." Again in a rather extensive illustrated section on the Circumcision of Infants, no reference is made to the modern method with a Gomco clamp which has almost entirely supplanted older techniques.

However, in spite of the above comments on a few of the matters treated in the work, it is well written and easily read, well arranged and commendably profuse with splendid, well-chosen illustrations.

It will be a very useful and concise reference book for the nurse who is interested in refreshing her knowledge of Obstetrics and Gynecology.

PAUL APPLETON, M.D.

PHYSICIANS' VITAMIN REFERENCE BOOK. By the Medical Division Professional Service Department of E. R. Squibb & Sons, pp. 126, E. R. Squibb & Sons, 745 Fifth Avenue, New York, 1938.

This is a useful compendium of the latest facts about vitamins.

The description of each of the vitamins is preceded by a useful condensed summary. Estimated daily requirements of various vitamins are stated in International Units where these are available. The vitamin potencies of a number of foods, selected because of their relatively high potency and general availability are also given.

The subject matter appears to have been carefully selected and conservatively presented, and it repeatedly reproduces the attitude of the Council of Pharmacy and Chemistry toward the clinical use of the vitamins in certain pathologic states. With a frankness that is commendable, negative reports are cited without bias, leaving, as should be done, the choice of therapy strictly with the physician.

The manufacturer does not state under what terms the book is available, so it must be inferred that any physician who is interested need only write to the firm to obtain a copy.